MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

12209

CERTIFICATE OF DEATH

Reg. Diat. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George W. Adams

3.(b) Social Security Number

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary E. Adams
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 31, 1881

8. AGE: Years: 64 | Months: 3 | Days: 17 | If less than one day: ..... hrs. ..... min.

8. Birthplace: Chas. Co. Md. (Town, cooty, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: William D. Adams
13. Birthplace: Chas. Co. Md.
MOTHER 14. Maiden name: Sarah Jane Robey
15. Birthplace: Chas. Co. Md.
18. Informant: Geo. Edwin Adams
Address: Waldorf, Md.
17. (Burial, cremation, or removal. Which?) Burial — Date thereof (month) (day) (year) 12/20/45
Cemetery or crematory: St. Paul's
Location: Waldorf, Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf, Md.
19. (Date rec'd by registrar) 12-19-45 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18, 1945, at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17, 1945, to Dec 18, 1945, and that I last saw him alive on Dec 18, 1945.

Immediate cause of death: Coronary Thrombosis — DURATION: 12-17-45
Due to: Gen. Arteriosclerosis & Coronary Heart Disease
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. (M. D. or other)
Address: La Plata Md. Date signed 12-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12210

Reg. Diat. No. 103

1. PLACE OF DEATH:
County: Charles
City or town: Bel alton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George Thompson Armsworthy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 2, 1889

8. AGE: Years	Months	Days	If less than one day
56	10	21	hrs. min.

9. Birthplace: St. Marys Co. Md.
(Town, county and state)
10. Usual occupation: Care Taker
11. Industry or business: Church
FATHER 12. Name: James Harrow Armsworthy
13. Birthplace: St Marys Co. Md.
MOTHER 14. Maiden name: Elizabeth Sullivan
15. Birthplace: St. Marys Co Md
16. Informant: James Cole Armsworthy
Address: Bel. alton
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/45 (month) (day) (year)
Cemetery or crematory: St. Ignatius
Location: Bel alton
18. Funeral director: Hunter & Ryon
Address: Medley, Md.
19. Rec'd Dec 26 1945 (Date rec'd by registrar) Mary E. Burch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23-45 at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	10-23-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. E. Medley M.D.
M. D. or other
Address: La Plata Md Date signed 12-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

12211

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clyde Leven Gates

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary I. Gates
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): June 26 1894
8. AGE: Years: 51 Months: Days: If less than one day: hrs. min.
9. Birthplace: Waldorf Md.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: Powder factory.
FATHER 12. Name: A. M. Gates.
13. Birthplace: Charles Co. Md.
MOTHER 14. Maiden name: Florence V. Baxter
15. Birthplace: Hughesville Md.
16. Informant: Johnnie Gates
Address: Indian Head Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26 1945 (month) (day) (year)
Cemetery or crematory: Piney Cemetery
Location: Waldorf, Md
18. Funeral director: Hunt & Ryon.
Address: Waldorf Md.
19. Dec. 25 1945 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23, 1945, at 6-20 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1939, to Dec 23 1945
and that I last saw h... alive on Dec. 23 1945
Immediate cause of death: Arterio-Sclerotic Nephritis — DURATION
Due to: Cardio-vascular renal disease
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Geo. C. Bickell M.D.
M. D. or other
Address: Marbury Md. Date signed: Dec 25 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-P)

CERTIFICATE OF DEATH

1221 ★ 705

Reg. Diat. No.

1. PLACE OF DEATH:
County: Charles
City or town: Welcome
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Welcome
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Virginia Gilroy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed

6.(b) Name of husband or wife: Thomas Gilroy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1873

8. AGE: Years	Months	Days	If less than one day
72	8	16	hrs. min.

9. Birthplace: Charles Co., Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: Richard Henderson
13. Birthplace: Va.
MOTHER — 14. Maiden name: Frances A. Posey
15. Birthplace: Chas. Co. Md.
16. Informant: Mrs. Allard Bowie
Address: Welcome Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8 / 45 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Nanjemoy
18. Funeral director: Hunter & Ryon
Address: Waldorf Md
19. Dec 7 19 45 M. L. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 19 at 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 45, to December 19 45
and that I last saw h-er alive on Dec. 3 19 45

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C. Bicknell M.D.
M. D. or other
Address: Marbury Md Date signed: 12-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

12213

CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH:

County Charles

City or town Doncaster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles.

City or town Doncaster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Beall Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife Rebecca Jackson

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 1 1877

8. AGE: Years	Months	Days	If less than one day
68	10	8	hrs. min.

9. Birthplace Charles Co. Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Bailey Jackson

13. Birthplace Charles Co. Md.

MOTHER 14. Maiden name Lucretia Wallace.

15. Birthplace Charles Co. Md.

16. Informant Rebecca Jackson

Address Doncaster Md.

17. Burial Date thereof Dec. 10 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Hope.

Location Mayfield Md

18. Funeral director Stanley Penny.

Address Mason Springs Md.

1945 Dec 8 1945 A. N. Thompson Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1945 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from , 1945 to Dec 8 1945

and that I last saw h alive on Dec. 1 1945

Immediate cause of death	DURATION
Cardio-vascular renal disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. C. Bicknell M.D.

M. D. or other

Address Marbury Md Date signed Dec. 9 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Burial permit

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(170-C)

12214

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: LaPlata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred: Chgo. Mem. Hosp. LaPlata Md
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Waldorf Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rudolph Miles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife: Victorine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: Chas Co Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Washington
13. Birthplace: Chas Co Md

MOTHER
14. Maiden name: Sarah
15. Birthplace: Chas Co Md

16. Informant: Victorine Miles
Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-6-45 (month) (day) (year)
Cemetery or crematory: Zion Wesley
Location: Waldorf Md

16. Funeral director: Hurst & Ryon
Address: Waldorf Md

19. 12-5 (Date rec'd by registrar) 1945 Julia H Pasey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12. 3 1945, at 12 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2 1945 to 12-3 1945
and that I last saw him alive on 12-3 1945

	DURATION
Immediate cause of death: Depressed fracture of skull	12-2-45
Due to: auto accident	12-2-45
Due to: (Coroner's Case)	
Other conditions: Compound comminuted fracture of tibia and left tibia and right (Include pregnancy within 3 months of death)	12-2-45

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 12-2-45
Where did injury occur? Waldorf (City or town) Charles (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public
Means of injury: auto hit him while walking (Injured at work?)

23. SIGNATURE: E J Edelen M.D. (M. D. or other)
Address: LaPlata Md Date signed 12-3-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13Fa)

CERTIFICATE OF DEATH

12215

Reg. Dist. No. 105

1. PLACE OF DEATH:
County Charles
City or town Waldorf,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Guy Moreland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Audrey Moreland
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11, 1900

8. AGE: Years	Months	Days	If less than one day
45	6	24	... hrs. ... min.

9. Birthplace Aquasco, Pr. Geo. Md. (Town, county, and state)
10. Usual occupation Manager Gas Station
11. Industry or business
FATHER 12. Name William Robert Moreland
13. Birthplace Aquasco Md
MOTHER 14. Maiden name Mary Wilkerson
15. Birthplace Aquasco, Md.
16. Informant R. Harry Moreland
Address Waldorf. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 7, 45 (month) (day) (year)
Cemetery or crematory St. Paul's
Location Rural Waldorf, Md.
18. Funeral director Hunt & Ryan
Address Waldorf, Md.
19. Dec 7 19 45 W. P. Moore Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 4 19 45 at 7 14 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 37 to 12/14 19 45
and that I last saw him alive on 12-14 19 45

Immediate cause of death Cerebral Apoplexy

Due to Cardio-Vas Renal Disease with Hypertension

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. A. Worley M.D. M.D. or other
Address Waldorf, Md Date signed 12/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12216 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Galland Green
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Charles
City or town: Galland Green
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Moreland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Robert

7. Birth date of deceased (mo., day, yr.): Sept 30 ch 1867

6.(c) If alive, give age: 78 years

8. AGE:

Years	Months	Days	If less than one day
74		16	hrs. min.

9. Birthplace: Malcolm Chas Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: George Wilkerson
13. Birthplace: Maleolmsville

MOTHER
14. Maiden name: Josephine Stewart
15. Birthplace: Chas Co

18. Informant: Harry Moreland
Address: Waldorf md

17. Burial, cremation, or removal. Which?: Burial
Date thereof: 12-29-45 (month) (day) (year)

Cemetery or crematory: St Peters
Location: Waldorf md

16. Funeral director: Hunt & Ryle
Address: Waldorf md

19. 12-28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/27/45, 19..., at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15/45, 19..., to 12/27/45, 19...
and that I last saw h... alive on 12/27/45, 19...

	DURATION
Immediate cause of death: Coronary Thrombosis	5 yrs
Due to: Fat Embolism & Strain	1 hr
Due to: Coronary Occlusion	12 hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel A Ryle M.D.
M. D. or other
Address: Bryantown Md Date signed: 12-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12217

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:
County: Newburg Charles County
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nannie Mary Shade

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: George A. Shade
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 26th 1877

8. AGE: Years	Months	Days	If less than one day
68	11	13	15 hrs. ..... min.

9. Birthplace: Newburg Charles Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Alex. Tolson
13. Birthplace: Newburg
MOTHER 14. Maiden name: Eliza Ware
15. Birthplace: Newburg Md.
16. Informant: Brookes A. Shade
Address: Newburg
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-16-45 (month) (day) (year)
Cemetery or crematory: Burial Shiloh Cemetary
Location: Shiloh, Md.
18. Funeral director: Penny and Cofer
Address: Mason Spring Md
19. 12/15 1945 William A. Frere
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13th 1945, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 3 1945, to December 13 1945 and that I last saw h.er alive on December 13 1945

Immediate cause of death	DURATION
Chronic Myocarditis	3 Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Emmett J. Gorman M.D.
M. D. or other
Address: Bel Alton Md. Date signed 12/13/45

VS A15

PLEASE WRITE PLAINLY, WITH INFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 12218 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
County: Charles
City or town: Pt. Hope Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred: 44 Greenwood Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Pt. Hope Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Greenwood Place.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Macie Edna Simmons

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jas. H. Simmons
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29. 1917

8. AGE: Years 28 | Months 6 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace: Wallace N.C.
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: own home.

FATHER 12. Name: Elbert Lewis
FATHER 13. Birthplace: Wallace N.C.

MOTHER 14. Maiden name: Mary Brock
MOTHER 15. Birthplace: Wallace N.C.

16. Informant: Jas. H. Simmons
Address: 44 Greenwood Pl. Pt. Hope

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45 (month) (day) (year)
Cemetery or crematory: Family Plot
Location: Rose Hill, North Carolina

18. Funeral director: Hunt & Ryan
Address: Waldorf, Md.

19. 12-27 1945 M. L. Mehrling
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 19 45 at 6 30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Dec 27 19 45
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute myocarditis	1 day.
Due to: Chronic myocarditis Heart disease	15 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank Simmons M.D.
M. D. or other
Address: Indian Head Md. Date signed 12/27/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

83-a

1221704

1. PLACE OF DEATH

County Charles Registration Dist. No. 704

Village or City Newburg No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ida M. Thomas If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	B.	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph F Thomas

6. DATE OF BIRTH (month, day, and year) 6-29-1888

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) May 1945

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Mount Victoria (State or country)

FATHER

13. NAME Philip Ford

14. BIRTHPLACE (city or town) Mount Victoria (State or country)

MOTHER

15. MAIDEN NAME Delila Mayhall

16. BIRTHPLACE (city or town) Mount Victoria (State or country)

17. INFORMANT Joseph F. Thomas (Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Shiloh Date 12-22-, 1945

19. UNDERTAKER Hunt & Ryan (Address) Waldorf

20. FILED 12-20-, 1945 Williams Shreve Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 12 (Month) – 18 (Day) – 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 12-18-, 1945, to 12-18-, 1945

I last saw her alive on 12-18-, 1945 death is said to have occurred on the date stated above, at 11 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Apoplexy	10-1-45
Other **Contributory Causes** of importance:	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) V. L. Dryden M. D.

(Address) Waldorf

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
DEC 26 1945

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A16 (1)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

12220

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: New Port, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants, give residence of mother)
State: Md County: Charles
City or town: Newport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Alice Geneva Tippett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband ~~or wife~~: Joseph Preston Tippett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 27, 1872

8. AGE: Years: 73 | Months: 7 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: New Port, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Noble Thompson
13. Birthplace: Chas. Co. Md.
MOTHER 14. Maiden name: Mary Simpson
15. Birthplace: Chas. Co. Md.
16. Informant: Mrs Judson Long
Address: New Port, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/21/45 (month) (day) (year)
Cemetery or crematory: St. Marys
Location: New Port, Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf Md.
19. 12-19 1945 M. R. Mudd (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 18 1945, at 1145 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-16 1945, to 12-18 1945 and that I last saw h alive on 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ernest Spencer Jr. M.D.
M. D. or other
Address: Bel Alton Md Date signed 12-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

12221

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: New Port
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Newport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Henry Whalen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Alice Whalen
Newport 6.(c) If alive, give age 31 years
7. Birth date of deceased (mo., day, yr.): May 7 - 1912

8. AGE: Years	Months	Days	If less than one day
33	7 mos		hrs. ____ min.

9. Birthplace: Virginia Charles County
(Town, county, and state)
10. Usual occupation: Farmer Laborer
11. Industry or business: Farm

FATHER
12. Name: William Henry Whalen
13. Birthplace: Virginia or Md -

MOTHER
14. Maiden name: Mary Jane Earley
15. Birthplace: St Marys Co

16. Informant: Alice Whalen
Address: New Port Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 10/45 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: New Port Md
18. Funeral director: Hunter & Payson
Address: Waldorf Md.

19 Dec 8 19 45 M. P. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/7/45 - 6 AM 19 ... et ... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/3/45 19 12/7/45 19
and that I last saw h alive on 12/4/45 19

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Bryantville Md Date signed 12/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12222

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Pisgah

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ months

Hospital, Institution, or street address where death occurred:

—

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Pisgah

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joyce Diane Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1945

8. AGE:

Years	Months	Days	If less than one day
0	2	22	... hrs. ... min.

9. Birthplace: Wash., D.C. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Daniel J. Williams

FATHER — 13. Birthplace: Pisgah, Md.

MOTHER — 14. Maiden name: Ida Mae Harvey

MOTHER — 15. Birthplace: Chapel Hill, Md.

16. Informant: Ida Mae Williams (mother)

Address: Pisgah, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 11 45 (month) (day) (year)

Cemetery or crematory: Smiths Chapel

Location: Pisgah Md.

18. Funeral director: Penny + Cofer

Address: Mason Springs Md.

19 Dec. 11 1945 (Date rec'd by registrar) Ruby Smithwick Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8, 1945, at about 4:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8, 1945, to ... 19..; and that I saw h[illegible] on Dec. 8, 1945

Immediate cause of death	DURATION
Peripheral vascular collapse	minutes
Due to: Probably lobar pneumonia	8 hrs.
Due to:	
Other conditions: Prematurity (birth wt. 5 lbs.)	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Deputy Medical Examiner James L. MacKavanagh, M.D. (M. D. or other)

Address: LaPlata, Md. Date signed 12-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

12223

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, Institution, or street address where death occured:
Physicians Memorial Hospital

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Mary Olivia Woodland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 26, 1891 JSM

8. AGE: Years	Months	Days	If less than one day
54 JSM	9	5	..... hrs. ..... min.

9. Birthplace: CHARLES County MD
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER
12. Name: John Johnson
13. Birthplace: Charles Co md

MOTHER
14. Maiden name: Mary Johnson
15. Birthplace: Charles Co md

16. Informant: Florene Bonds (daughter)
Address: Hughesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-3-45 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: Bryantown - Md

18. Funeral director: Elmer M. Quade

Address: Hughesville Md

19. 1-2 (Date rec'd by registrar) 1946 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1945, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 30 1945 to Dec. 31 1945 and that I last saw h[illegible] alive on Dec. 31, 1945

Immediate cause of death	DURATION
Congestive heart failure	1-2 mos
Due to: Hypertensive heart disease	1-2 mos.
Due to: Chronic diffuse glomerulonephritis	Unknown
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James L. MacKaye M.D.
M. D. or other

Address: La Plata, Md Date signed 12-31-45